



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645

(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Harparminder Chadha, M.D.

Respondent Name

XL Specialty Insurance Company

MFDR Tracking Number

M4-16-3020-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

June 3, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The bill has been submitted to the carrier multiple times, as evidenced in the accompanying paperwork, but both bill review and the adjuster have apparently refused to process the claim."

Amount in Dispute: \$350.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Division Note: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged as received on June 13, 2016. 28 Texas Administrative Code §133.307(d)(1) requires that:

The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

The insurance carrier did not submit a response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 11, 2016	Designated Doctor Examination	\$350.00	\$350.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §133.10 sets out the requirements for submission of a medical bill.
3. 28 Texas Administrative Code §133.240 sets out the procedures for payment or denial of a medical bill.
4. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services.
5. Submitted documentation did not include explanations of benefits.

Issues

1. Did the requestor submit a complete medical bill?
2. Did the insurance carrier deny the medical bill in accordance with 28 Texas Administrative Code §133.240?
3. What is the maximum allowable reimbursement (MAR) for the disputed service?
4. Is the requestor entitled to reimbursement for the disputed service?

Findings

1. The requestor is seeking reimbursement for a designated doctor examination for date of service August 11, 2015. The requestor argues that the original bill for this service was submitted on August 28, 2015. 28 Texas Administrative Code §133.10 defines the required elements for a complete medical bill. Review of the submitted documentation supports that the requestor submitted a complete medical bill to the insurance carrier on August 28, 2015.

2. 28 Texas Administrative Code §133.240(a) states:

An insurance carrier shall take final action after conducting bill review on a complete medical bill, or determine to audit the medical bill in accordance with §133.230 of this chapter (relating to Insurance Carrier Audit of a Medical Bill), not later than the 45th day after the date the insurance carrier received a complete medical bill. An insurance carrier's deadline to make or deny payment on a bill is not extended as a result of a pending request for additional documentation.

The submitted documentation does not include an explanation of benefits or response from the insurance carrier. The division finds that the insurance carrier did not deny the disputed service in accordance with 28 Texas Administrative Code §133.240 and will therefore be reviewed per applicable fee guidelines.

3. Per 28 Texas Administrative Code §134.204(j)(2)(A),

If the examining doctor, other than the treating doctor, determines MMI has not been reached, the MMI evaluation portion of the examination shall be billed and reimbursed in accordance with paragraph (3) of this subsection. Modifier "NM" shall be added.

Paragraph (3) states, "The following applies for billing and reimbursement of an MMI evaluation... (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be \$350." The submitted documentation supports that the requestor performed an evaluation of MMI and found that the injured employee was not at MMI. Therefore, the correct MAR for this examination is \$350.00.

4. The total MAR for the disputed service is \$350.00. The insurance carrier paid \$0.00. A reimbursement of \$350.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$350.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$350.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____ Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	July 28, 2016 Date
--------------------	---	-----------------------

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.